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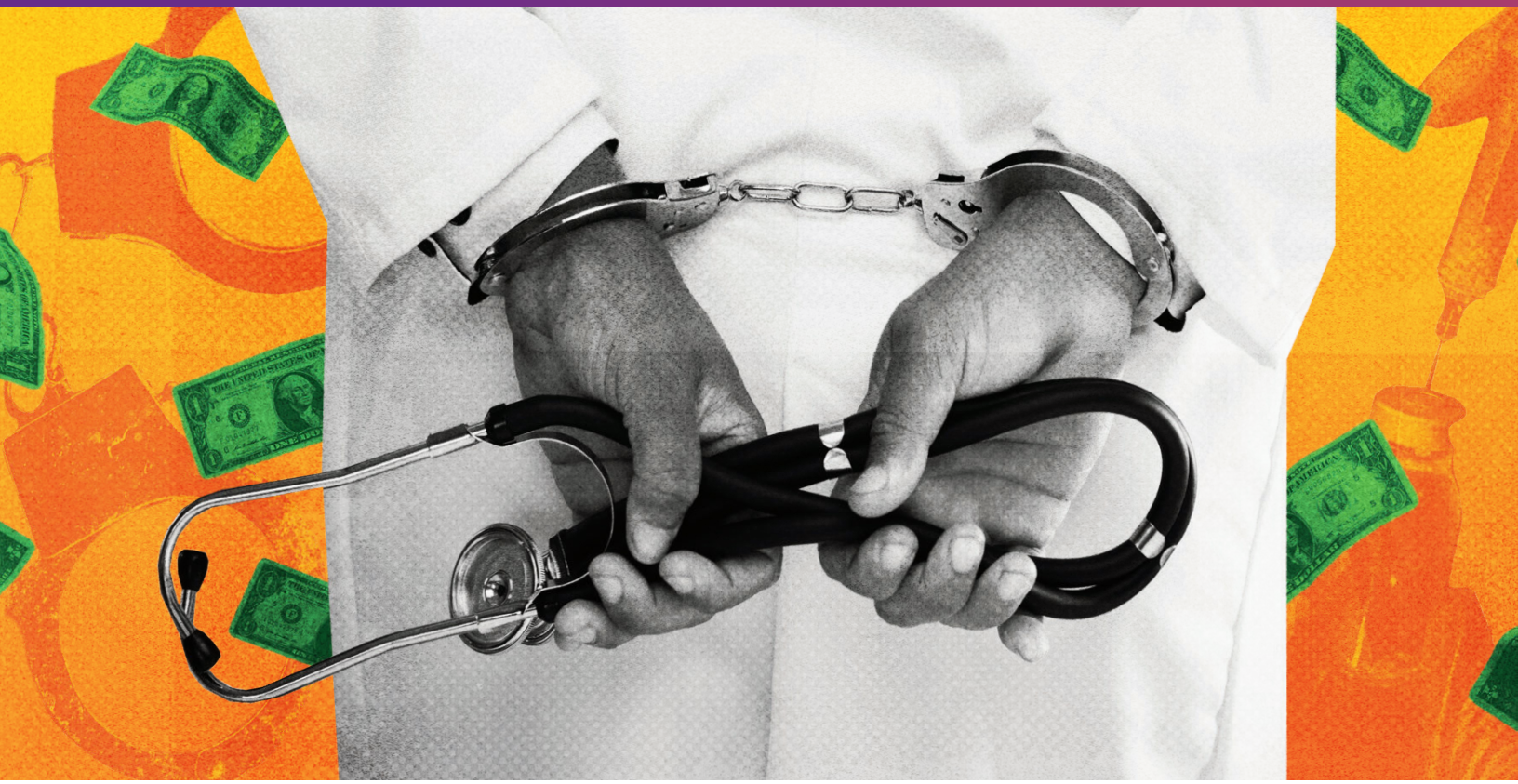
FVS Eye on Fraud

The AICPA Forensic and Valuation Services quarterly report on fraud trends and topics



Medical and insurance fraud: A prescription for financial loss

Issued by the AICPA FLS Fraud Task Force
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"The overwhelming majority of health care providers, including physicians, nurses, physical therapists and pharmacists are caring, honest professionals. Unfortunately, a very small number of providers and health care organizations have chosen to cheat insurers, their patients and clients by committing health insurance fraud. This fraud steals hundreds of millions of dollars every year that could have been spent to help people. All of us pay for this with higher insurance premiums and taxes."[1] This quote is directly from the State of Connecticut's Insurance Department website and echoes the sentiment felt in all 50 states.

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Inside this issue

[1] "What Can We Do To Combat Health Insurance Fraud?" State of Connecticut Insurance Department, https://portal.ct.gov/CID/Fraud/Fraud/What-Can-We-Do-To-Combat-Health-Insurance-Fraud (accessed July 14, 2021).

We see news of fraud happening almost daily that affects our financial well-being, but what about the fraud that affects our physical well-being? Health care fraud is a dual threat: it affects both the financial and physical well-being of the victim. The fraud does not simply take money from individuals, insurance carriers or federal agencies. This fraud can compromise the health of the individuals affected by the fraud.

In 2016, the Centers for Medicare and Medicaid Services (CMS) spent $1.1 trillion on health coverage for about 145 million Americans, $95 billion of which included improper payments due to abuse as a result of fraud.[2] This amounted to about 8.6% of the total amount spent on health coverage. In 2018, $3.6 trillion was spent on health care in the United States.[3] This amount includes health care from the CMS, government agencies and insurance companies. Although there is no exact figure to calculate how much fraud exists in the health care system, it is estimated that 3% to 10% of all health care expenditures are fraudulent, which equates to upwards of $300 billion in fraud.

To put health care fraud into perspective the AARP (formerly the American Association of Retired Persons) determined in 2017 that Medicare fraud totaled $68 billion.[4] By way of comparison, the annual fiscal budget for the Department of Homeland Security and NASA totaled $42 billion and $19 billion, respectively.[5] The $60 billion of fraud estimated by the AARP is a small estimate compared to the other estimates totaling $300 billion of fraud in the United States.

Common types of health care fraud

These are the primary areas the FBI identified:[6]

Fraud by medical providers

- **Double billing** — Submitting multiple claims for the same service
- **Phantom billing** — Billing a service or supplies the patient never received
- **Unbundling** — Submitting multiple bills for the same service
- **Upcoding** — Billing a more expensive service or supply than the patient received

Fraud by patients and other individuals

- **Bogus marketing** — Convincing individuals to provide their health identification number and other personal information to bill for non-rendered services, steal their identity or enroll them in a fake benefit plan.
- **Identity theft** — Using another person's health insurance or allowing another person to use their insurance.
- **Impersonating a health care professional** — Providing or billing for health care services or supplies without a license.

Fraud with prescriptions

- **Forgery** — Creating or using forged prescriptions.
- **Diversion** — Diverting legal prescriptions for illegal uses, such as selling medication or personal prescription medicine.
- **Doctor shopping** — Visiting multiple providers to get prescriptions for controlled substances or getting prescriptions from medical offices engaging in unethical practices.

With a wide array of tools and tactics to benefit fraudsters, what has been the government's response to medical fraud? The Department of Justice (DOJ) is increasing its efforts to combat medical and insurance fraud. The DOJ relies on the False Claims Act — which prosecutes those who provide false claims for federal funds and property — to prosecute medical fraud. In 2020, the DOJ obtained $1.8 billion in settlements from medical fraud from civil cases prosecuted under the False Claims Act.[7] The False Claims Act has recovered about $64 billion in settlements since 1986, totaling, on average, $1.8 billion in settlements per year. The DOJ recognizes the threat of medical fraud and created a Health Care Fraud Unit (HCFU), whose sole mission is to prosecute cases related to medical and insurance fraud, involving either harm to the patient or large financial losses.[8]

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[2] Drabiak, K. and Wolfson, J., "What Should Health Care Organizations Do to Reduce Billing Fraud and Abuse?" AMA Journal of Ethics, https://journalofethics.ama-assn.org/article/what-should-health-care-organizations-do-reduce-billing-fraud-and-abuse/2020-03 (accessed July 14, 2021).

[3] "The Challenge of Health Care Fraud," National Health Care Anti-Fraud Association, https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/ (accessed July 14, 2021).

[4] "Statistics," Blue Cross Blue Shield Blue Care Network of Michigan, https://www.bcbsm.com/health-care-fraud/fraud-statistics.html#:~:text=The%20National%20Heath%20Care%20Anti,trillion%20in%20health%20care%20spending (accessed July 14, 2021).

[5] Eaton, J., "Medicare Under Assault from Fraudsters," AARP, https://www.aarp.org/money/scams-fraud/info-2018/medicare-scams-fraud-identity-theft.html (accessed July 14, 2021).

[6] "Health Care Fraud," FBI.gov, https://www.fbi.gov/scams-and-safety/common-scams-and-crimes/health-care-fraud (accessed July 14, 2021).

[7] "Justice Department Recovers Over $2.2 Billion from False Claims Act Cases in Fiscal Year 2020," U.S. Department of Justice, https://www.justice.gov/opa/pr/justice-department-recovers-over-22-billion-false-claims-act-cases-fiscal-year-2020 (accessed July 27, 2021).

[8] "Health Care Fraud Unit," U.S. Department of Justice, https://www.justice.gov/criminal-fraud/health-care-fraud-unit (accessed July 14, 2021).

The HCFU is a multi-government agency initiative, combining resources from the FBI, U.S. Department of Health and Human Services (DHHS), the CMS, and other state and local agencies. The HCFU's largest single recovery came in 2019 from the drug industry. The HCFU recovered and settled $591 million from a drug company to resolve the claim that the company paid kickbacks to doctors who prescribed their drugs.[9]

In 2017, the HCFU charged 220 individuals who collectively charged $1.5 billion in fraudulent medical charges.[10] In 2020, that amount increased to 344 individuals who stole about $4.1 billion.

In response to the growing threat and losses due to health care fraud in 2014, DHHS and the CMS received $571.7 million in budgetary resources to identify, investigate, and prosecute health care fraud. In 2014, DHHS and the CMS recovered $3.3 billion related to settlements from medical and insurance fraud.

According to the U.S. Government Accountability Office (GAO) in 2010, 739 health care fraud cases were resolved.[11] Of those 739 cases, medical providers conducted 62% of the fraud and individual beneficiaries conducted 14%.[12] The GAO study illustrated that medical providers conducted the majority of the fraud. Although there have been several convictions for multimillion-dollar fraud schemes that defrauded the programs, the full scope and extent of the fraud is unknown. The GAO noted that Medicare and Medicaid programs are at high risk for fraud because of the size, scope and complexity of the programs, which make them vulnerable to fraud and abuse.

The CMS categorizes fraud and integrity issues into four categories:

1. Administrative mistakes
2. Management inefficiency by ordering a surplus of inventory
3. Abuse of rules (for example, upcoding claims)
4. Intentional fraud[13]

Federal laws for medical and insurance fraud and abuse

Prosecutors and investigators use several civil and criminal laws against fraudsters, including the False Claims Act, Anti-Kickback Statute, Physician Self-Referral Law, Social Security Act, Civil Monetary Penalties Law and the United States Criminal Code.[14] Government officials use these laws as a way to prosecute health care fraud and also as a deterrent by enforcing steep penalties.

Impact on clients

Why should we care about health care fraud? If this type of fraud affects insurance companies or government programs, how does that affect me or my clients?

- **Increased costs** — Fraudulent expenses lead to higher premiums for insurance, copays and increased costs for doctor visits.
- **Identity theft** — Medical identity theft costs individuals time and money. The fraud could also affect personal well-being by using up all the benefits from the services people may need.
- **Health risks** — When visiting a health care professional, patient medical histories are used to assist the provider with treatment. Unethical providers could place their patients' health at risk and order unnecessary services and supplies just to increase their billings.

[9] See footnote 7.

[10] Facts & Statistics, U.S. Department of Justice, https://www.justice.gov/criminal-fraud/facts-statistics (accessed July 14, 2021).

[11] Jimenez, A., "Health care Fraud During a Pandemic: Fast Facts for Financial Institutions," Thomson Reuters, https://legal.thomsonreuters.com/en/insights/articles/health care-fraud-during-a-pandemic#3 (accessed July 14, 2021).

[12] "Health Care Fraud: Information on the Most Common Schemes and the Likely Effect of Smart Cards," U.S. Government Accountability Office, https://www.gao.gov/assets/gao-16-216.pdf (accessed July 14, 2021).

[13] "Medicare Fraud & Abuse: Prevent, Detect, Report," Medical Learning Network, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf (accessed July 14, 2021).

[14] See footnote 12.

The red flags of medical fraud

As mentioned previously, we can all do our part by closely reviewing EOBs and ensuring all entries are correct. However, having a keen eye on all types of medical billing can assist in identifying some of the red flags of medical fraud, including the following:

- Ensuring unnecessary services are not billed
- Looking for duplicate billings for the same service on different dates
- Identifying procedures that were performed in one visit but are billed over a period of days or weeks
- Continual issues with coding of procedures
- Billing for services not rendered
- No follow-up visits or treatment when the listed diagnosis would appear to warrant it

As discussed previously, fraudsters will use any means possible to defraud the health care system without any thought to the people they may hurt. Health care fraud is not a victimless crime, and it preys on individuals and corporations without hesitation.

COVID-19 impact

Fraudsters do not care if the world is amid a pandemic. Fraud related to the COVID-19 pandemic has not yet been quantified; however, the FBI and other agencies are aware of the many schemes that have evolved as a result of the pandemic. DHHS issued an alert related to fraud schemes during the COVID-19 pandemic. According to DHHS, scammers have been using telemarketing calls, text messages, social media platforms and door-to-door visits to conduct COVID-19 scams.[15] Parts of these schemes include using the pandemic as a pretense to offer fraudulent COVID-19 tests, providing prescription cards in exchange for personal information, fraudulently billing federal health care programs and committing identity theft.

How are fraudsters using the COVID-19 pandemic to benefit themselves? The U.S. Treasury Financial Crimes Enforcement Network identified several instances of potential fraud related to health care benefit programs, health insurance and COVID-19 relief funds.[16]

- **Unnecessary services** — Ordering or submitting claims for expensive services that do not test for or detect the presence of COVID-19 antibodies. These services include respiratory testing, allergy testing, genetic testing, narcotics screening or full-body assessments, among other services.
- **Billing fraud** — Billing for services not provided or overbilling for services related to COVID-19 testing and treatments.
- **Kickbacks** — Paying service providers or marketing organizations an illegal kickback in exchange for ordering services.
- **Health care technology fraud** — False and fraudulent representations about COVID-19 testing or treatments to defraud insurance carriers.
- **Telehealth fraud** — Collecting individuals' personal information, including Medicare information, through fraudulent solicitations. Fraudsters use this information to submit claims for payment.
- **Obtaining COVID-19 health care relief funds** — Filing false claims and applications for federal relief funds relating to COVID-19.

Medical and insurance fraud continues to be a big problem in the United States. Health care fraud has existed and will continue to exist well after the COVID-19 pandemic. Fraud tactics may change over time, but the impact on our society will remain the same. To minimize the lasting effects of fraud, we must be diligent in ensuring our personal information is correct and adequately guarded. We must also ensure our elder family members are educated and aware of the threat.

[15] "Fraud Alert: COVID-19 Scams," U.S. Department of Health and Human Services, https://oig.hhs.gov/fraud/consumer-alerts/fraud-alert-covid-19-scams/ (accessed July 14, 2021).

[16] "Advisory on COVID-19 Health Insurance and Health Care-Related Fraud," FinCEN Advisory, https://www.fincen.gov/sites/default/files/advisory/2021-02-02/COVID-19%20Health%20Care%20508%20Final.pdf (accessed July 14, 2021).

Case studies in health care fraud

- In September 2020, six individuals were arrested and charged in New Jersey for their roles in a $100 million nationwide prescription and durable medical equipment telemedicine scheme. Of the six arrested, three individuals admitted to other fraudulent schemes committed that are unrelated to the charges.[17]
- In April 2021, five individuals in New Jersey were charged for a $93 million durable medical equipment and genetic cancer screening kickback fraud scheme.[18]
- In May 2021, the Department of Justice (DOJ) charged 14 individuals, who were telemedicine executives, physicians, marketers and medical business owners for a COVID-19–related fraud scheme exceeding $145 million.
- The DOJ settled with a group of Rhode Island medical providers who fraudulently billed Medicaid and Medicare for urine drug screens that they did not perform. The defendants will pay $650,000 to settle the suit that claimed they received over $1.5 million in payments.[19]
- A former chiropractor was found guilty of defrauding health insurers by submitting $2.2 million in fraudulent billings for services never provided as well as false diagnoses and office visits. The defendant also submitted fraudulent prescriptions with fabricated medical diagnoses. The statutory maximum sentence is 67 years for these offenses.[20]

Practice tips for the Practitioner

As this article has already highlighted, health care fraud is a pervasive problem, starting with the individual up to the federal government. If the federal government and companies cannot stop fraud with all the resources and tools they have, how can we protect ourselves and our clients from becoming victims of fraud?:

- Treat health care information as you would your driver's license or Social Security number.
- With the plethora of phone calls and emails that are exercises in phishing, do not give information to anyone you do not know or trust, and be especially mindful when using it at a medical provider. Regularly check your benefits statements to reconcile services provided with charges made.
- Like a bank statement, check your insurance explanation of benefits (EOBs) regularly, making sure locations, charges, and services match what occurred.
- Be aware of "free" services; the service may not be free and actually may be charged to the insurance carrier.

Some of these concepts have been discussed in prior issues of *Eye on Fraud* on the subjects of phishing and elder fraud, but further discussion of these concepts is necessary because this is an ongoing problem in so many aspects of everyday life.

Resources

In addition to the resources already mentioned in this article, the following is a list of useful governmental and other agencies that deal with fraudulent activity:

- Medicare
- U.S. Department of Health and Human Services, Offices of the Inspector General
- Centers for Medicare & Medicaid Services
- FBI
- U.S. Department of Justice, Health Care Fraud Unit
- Many health care providers and insurance companies also have websites specifically for information on health care fraud and methods of reporting.

[17] U.S. State Attorney's Office, District of NJ, "District of New Jersey Announces Charges in Health Care Fraud Cases as Part of Nationwide Federal Law Enforcement Effort, U.S. Attorney's Office District of New Jersey," https://www.justice.gov/usao-nj/pr/district-new-jersey-announces-charges-health-care-fraud-cases-part-nationwide-federal-law (accessed July 14, 2021).

[18] U.S. State Attorney's Office, District of NJ, "Five People Charged, Two Others Admit Guilt, in $93 Million Health Care Fraud Scheme," U.S Attorney's Office District of New Jersey, https://www.justice.gov/usao-nj/pr/five-people-charged-two-others-admit-guilt-93-million-health-care-fraud-scheme (accessed July 14, 2021).

[19] Serreze, M., "Feds Settle Fraud Lawsuit Against N. Smithfield Medical Clinic," Patch.com, https://patch.com/rhode-island/northsmithfield/feds-settle-fraud-lawsuit-against-n-smithfield-medical-clinic (accessed July 14, 2021).

[20] U.S. State Attorney's Office, District of CA, "Former Chiropractor Found Guilty of Health Care Fraud Charges that She Schemed to Defraud health Insurers Out of $2.2 Million", U.S. Attorney's Office Central District of California, https://www.justice.gov/usao-cdca/pr/former-chiropractor-found-guilty-health-care-fraud-charges-she-schemed-defraud-health (accessed July 14, 2021).

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